109TH CONGRESS
1ST SESSION

S. 1227

To improve quality in health care by providing incentives for adoption of modern information technology.

IN THE SENATE OF THE UNITED STATES

JUNE 13, 2005

Ms. STABENOW (for herself and Ms. SNOWE) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To improve quality in health care by providing incentives for adoption of modern information technology.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Information Technology Act of 2005''.

SEC. 2. INFORMATICS SYSTEMS GRANT PROGRAM.

(a) GRANTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a program to award

grants to eligible entities that have submitted applications in accordance with subsection (b) for the purpose of assisting such entities in offsetting the costs incurred after December 31, 2004, that are related to clinical health care informatics systems and services designed to improve quality in health care and patient safety.

(2) DURATION.—The authority of the Secretary to make grants under this section shall terminate on September 30, 2010.

(3) COSTS DEFINED.—For purposes of this section, the term ''costs'' shall include total expenditures incurred for—

(A) purchasing, leasing, and installing computer software and hardware, including handheld computer technologies, and related services;

(B) making improvements to existing computer software and hardware;

(C) purchasing or leasing communications capabilities necessary for clinical data access, storage, and exchange;

(D) services associated with acquiring, implementing, operating, or optimizing the use of new or existing computer software and hard-

ware and clinical health care informatics systems;

(E) providing education and training to eligible entity staff on information systems and technology designed to improve patient safety and quality of care; and

(F) purchasing, leasing, subscribing, integrating, or servicing clinical decision support tools that—

(i) integrate patient-specific clinical data with well-established national treatment guidelines; and

(ii) provide ongoing continuous quality improvement functions that allow providers to assess improvement rates over time and against averages for similar providers.

(4) ELIGIBLE ENTITY DEFINED.—For purposes of this section, the term ''eligible entity'' means the following entities:

(A) HOSPITAL.—A hospital (as defined in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e))).

(B) CRITICAL ACCESS HOSPITAL.—A critical access hospital (as defined in section

1861(mm)(1) of such Act (42 U.S.C. 1395x(mm)(1))).

(C) SKILLED NURSING FACILITY.—A skilled nursing facility (as defined in section 1819(a) of such Act (42 U.S.C. 1395i–3(a))).

(D) FEDERALLY QUALIFIED HEALTH CENTER.—A Federally qualified health center (as defined in section 1861(aa)(4) of such Act (42 U.S.C. 1395x(aa)(4))).

(E) PHYSICIAN.—A physician (as defined in section 1861(r) of such Act (42 U.S.C. 1395x(r))).

(F) PHYSICIAN GROUP PRACTICE.—A physician group practice.

(G) COMMUNITY MENTAL HEALTH CENTER.—A community mental health center (as defined in section 1861(ff)(3)(B) of such Act (42 U.S.C. 1395x(ff)(3)(B))).

(b) APPLICATION.—

(1) IN GENERAL.—An eligible entity seeking a grant under this section shall submit an application to the Secretary at such time, in such form and manner, and containing the information described in paragraph (2).

(2) INFORMATION DESCRIBED.—The information described in this paragraph is the following information:

(A) A description of—

(i) the clinical health care informatics system and services that the eligible entity intends to implement with the assistance received under this section; and

(ii) how the system will improve quality in health care and patient safety, including estimates of the impact on the health of, and the health costs associated with the treatment of, patients with heart disease, cancer, stroke, diabetes, chronic obstructive pulmonary disease, asthma, or any other disease or condition specified by the Secretary.

(B) Any additional information that the Secretary may specify.

(c) PRIORITY FOR CERTAIN ELIGIBLE ENTITIES.—In awarding grants under this section, the Secretary shall give priority—

(1) first, to eligible entities—

(A) that are exempt from tax under section 501(a) of the Internal Revenue Code of 1986; and

(B)(i) in which the total of individuals that are eligible for benefits under the medicare program under title XVIII of the Social Security Act, the medicaid program under title XIX of such Act, or under the State children's health insurance program under title XXI of such Act make up a high percentage (as determined appropriate by the Secretary) of the total patient population of the entity; or

(ii) that provide services to a large number (as determined appropriate by the Secretary) of such individuals;

(2) then, to eligible entities that meet the requirement under clause (i) or (ii) of paragraph (1)(B); and

(3) then, to other eligible entities.

(d) RESERVE FUNDS FOR ENTITIES IN HEALTH PROFESSIONAL SHORTAGE AREAS OR RURAL AREAS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall ensure that at least 20 percent of the funds available for making grants under this section to—

(A) hospitals and critical access hospitals are used for making grants to such hospitals that are located exclusively in an applicable area;

(B) skilled nursing facilities are used for making grants to such facilities that are located exclusively in an applicable area;

(C) Federally qualified health centers are used for making grants to such centers that are located exclusively in an applicable area;

(D) physicians and physician group practices are used for making grants to physicians and such practices that are located exclusively in an applicable area; and

(E) community mental health centers are used for making grants to such centers that are located exclusively in an applicable area.

(2) AVAILABILITY OF RESERVE FUNDS IF LIMITED NUMBER OF ENTITIES APPLY FOR RESERVED GRANTS.—If the Secretary estimates that the amount of funds reserved under subparagraph (A), (B), (C), (D), or (E) of paragraph (1) for the type of entity involved exceeds the maximum amount of funds permitted for such entities under subsection (e), the Secretary may reduce the amount reserved

for such entities by an amount equal to such excess and use such funds for awarding grants to other eligible entities.

(3) APPLICABLE AREA DEFINED.—For purposes of paragraph (1), the term ''applicable area'' means—

(A) an area that is designated as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act;

(B) a rural area (as such term is defined for purposes of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d))); or

(C) a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

(e) AMOUNT OF GRANT.—

(1) AMOUNT.—

(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (2), the Secretary shall determine the amount of a grant awarded under this section.

(B) CONSIDERATION.—In determining the amount of a grant under this section, the Secretary shall take into account the ability to take an expense deduction for health care informatics system expenses under section 179C of the Internal Revenue Code of 1986, as added by section 5.

(2) LIMITATION.—

(A) IN GENERAL.—A grant awarded under this section may not exceed the lesser of—

(i) an amount equal to the applicable percentage of the costs incurred by the eligible entity for the project for which the entity is seeking assistance under this section; or

(ii) in the case of a grant made to—

(I) a hospital or a critical access hospital, $1,000,000;

(II) a skilled nursing facility, $200,000;

(III) a Federally qualified health center, $150,000;

(IV) a physician, $15,000;

(V) a physician group practice, an amount equal to $15,000 multi-

plied by the number of physicians in the practice; or

(VI) a community mental health center, $75,000.

(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A)(i), the term ''applicable percentage'' means, with respect to an eligible entity for the period involved, the percentage of total revenues (excluding grants and gifts from Federal, State, local government, and private sources) for such period that consists of total revenues from the medicare program, the medicaid program, and the State children's health insurance program under titles XVIII, XIX, and XXI, respectively, of the Social Security Act.

(f) REQUIREMENTS.—

(1) COMPLIANT WITH STANDARDS.—A clinical health care informatics system funded under this section and placed in service on or after the date the standards are adopted under section 4 shall be compliant with such standards.

(2) FURNISHING THE SECRETARY WITH INFORMATION.—

(A) IN GENERAL.—An eligible entity receiving a grant under this section shall furnish the Secretary with such information as the Secretary may require to—

(i) evaluate the project for which the grant is made; and

(ii) ensure that assistance provided under the grant is expended for the purposes for which it is made.

(B) COORDINATION.—The Secretary shall ensure that the requirements for furnishing information under subparagraph (A) are coordinated with other requirements for furnishing information to the Secretary that the eligible entity is subject to.

(g) STUDIES.—The Secretary shall conduct studies to—

(1) evaluate the use of clinical health care informatics systems and services implemented with assistance under this section to measure and report quality data based on accepted clinical performance measures; and

(2) assess the impact of such systems and services on improving patient care, reducing costs, and increasing efficiencies.

(h) REPORTS.—

(1) INTERIM REPORTS.—

(A) IN GENERAL.—The Secretary shall submit, at least annually, a report to the appropriate committees of Congress on the grant program established under this section.

(B) CONTENTS.—A report submitted pursuant to subparagraph (A) shall include information on—

(i) the number of grants made;

(ii) the nature of the projects for which assistance is provided under the grant program;

(iii) the geographic distribution of grant recipients;

(iv) the impact of the projects on the health of, and the health costs associated with the treatment of, patients with heart disease, cancer, stroke, diabetes, chronic obstructive pulmonary disease, asthma, or any other disease or conditions specified by the Secretary;

(v) the results of the studies conducted under subsection (g); and

(vi) such other matters as the Secretary determines appropriate.

(2) FINAL REPORT.—Not later than 180 days after the completion of all of the projects for which assistance is provided under this section, the Secretary shall submit a final report to the appropriate committees of Congress on the grant program established under this section, together with such recommendations for legislation and administrative action as the Secretary determines appropriate.

(i) FUNDING.—

(1) HOSPITALS.—There are appropriated from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) $250,000,000, for each of the fiscal years 2006 through 2010, for the purpose of making grants under this section to eligible entities that are hospitals or critical access hospitals.

(2) SKILLED NURSING FACILITIES.—There are appropriated from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) $100,000,000, for each of the fiscal years 2006 through 2010, for the purpose of making grants under this section to eligible entities that are skilled nursing facilities.

(3) FEDERALLY QUALIFIED HEALTH CENTERS.—There are appropriated from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) $40,000,000, for each of the fiscal years 2006 through 2010, for the purpose of making grants under this section to eligible entities that are Federally qualified health centers.

(4) PHYSICIANS.—There are appropriated from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) $400,000,000, for each of the fiscal years 2006 through 2010, for the purpose of making grants under this section to eligible entities that are physicians or physician group practices.

(5) COMMUNITY MENTAL HEALTH CENTERS.—There are appropriated from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) $20,000,000, for each of the fiscal years 2006 through 2010, for the purpose of making grants under this section to eligible entities that are community mental health centers.

SEC. 3. ADJUSTMENTS TO MEDICARE PAYMENTS FOR HEALTH INFORMATION TECHNOLOGY ENABLED QUALITY SERVICES.

(a) ADJUSTMENTS.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a methodology for making adjustments in payment amounts under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) made to providers of services and suppliers who—

(1) furnish items or services for which payment is made under such title; and

(2) in the course of furnishing such items and services, use health information technology and technology services with patient-specific applications that the Secretary determines improves the quality and accuracy of clinical decision-making, compliance, health care delivery, and efficiency, such as electronic medical records, electronic prescribing, clinical decision support tools integrating well-established national treatment guidelines with continuous quality improvement functions, and computerized physician order entry with clinical decision-support capabilities.

(b) REQUIREMENTS.—The methodology established under subsection (a) shall—

(1) include the establishment of new codes, modification of existing codes, and adjustment of evaluation and management modifiers to such codes, that take into account the costs of acquiring, using, and maintaining health information technology and services with patient-specific applications;

(2) first address adjustments for payments for items and services related to the diagnosis or treatment of heart disease, cancer, stroke, diabetes, chronic obstructive pulmonary disease (COPD), and other diseases and conditions that result in high expenditures under the medicare program and for which effective health information technology exists; and

(3) take into account estimated aggregate annual savings in overall payments under such title XVIII attributable to the use of health information technology and services with patient-specific applications.

(c) DURATION.—The Secretary may reduce or eliminate adjustments made to payments pursuant to subsection (a) as payment methodologies under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) are adjusted to reflect provider quality and efficiency.

(d) RULE OF CONSTRUCTION.—In making national coverage determinations under section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) with respect to maintaining health information technology and services with patient-specific applications, in determining whether the health information technology and services are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, the Secretary shall consider whether the health information technology and services improve the health of medicare beneficiaries, including the improvement of clinical outcomes or cost-effectiveness of treatment.

(e) DEFINITIONS.—In this section:

(1) PROVIDER OF SERVICES.—The term ''provider of services'' has the meaning given that term under section 1861(u) of the Social Security Act (42 U.S.C. 1395x(u)).

(2) SUPPLIER.—The term ''supplier'' has the meaning given that term under section 1861(d) of such Act (42 U.S.C. 1395x(d)).

SEC. 4. INTEROPERABILITY.

(a) DEVELOPMENT AND ADOPTION OF STANDARDS.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall provide for the development and adoption under programs administered by the Secretary of national data and communication health information technology standards that promote the efficient exchange of data between varieties of provider health information technology systems. In carrying out the preceding sentence, the Secretary may adopt existing standards consistent with standards established under subsections (b)(2)(B)(i) and (e)(4) of section 1860D–4 of the Social Security Act (42 U.S.C. 1395w–104).

(2) REQUIREMENTS.—The standards developed and adopted under paragraph (1) shall be designed to—

(A) enable health information technology to be used for the collection and use of clinically specific data;

(B) promote the interoperability of health care information across health care settings, including reporting to the Secretary and other Federal agencies; and

(C) facilitate clinical decision support through the use of health information technology.

(b) IMPLEMENTATION OF PROCEDURES FOR THE SECRETARY TO ACCEPT DATA USING STANDARDS.—

(1) DATA FROM NEW HEALTH CARE REPORTING REQUIREMENTS.—Not later than January 1, 2008, the Secretary shall implement procedures to enable the Department of Health and Human Services to accept the optional submission of data derived from health care reporting requirements established after the date of enactment of this Act using data standards adopted under this section.

(2) DATA FROM ALL REQUIREMENTS.—

(A) IN GENERAL.—Not later than January 1, 2010, the Secretary shall implement procedures to enable the Department of Health and Human Services to accept the optional submission of data derived from all health care reporting requirements using data standards adopted under this section.

(B) LIMITATION.—

(i) IN GENERAL.—On and after January 1, 2010, if an entity or individual elects to submit data to the Secretary

using data standards adopted under this section, the Secretary, subject to clause (ii), may not require such entity or individual to also submit such data in an additional format.

(ii) EXCEPTION.—The Secretary may provide for an exception, not to exceed 2 years, to the limitation under clause (i) with respect to certain types of data if the Secretary determines that such an exception is appropriate.

SEC. 5. ELECTION TO EXPENSE HEALTH CARE INFORMATICS SYSTEMS.

(a) IN GENERAL.—Part VI of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to itemized deductions for individuals and corporations) is amended by inserting after section 179B the following new section:

"SEC. 179C. HEALTH CARE INFORMATICS SYSTEM EXPENDITURES.

''(a) TREATMENT OF EXPENDITURES.—

''(1) IN GENERAL.—An eligible entity may elect to treat any qualified health care informatics system expenditure which is paid or incurred by the taxpayer as an expense which is not chargeable to cap-

ital account. Any expenditure which is so treated shall be allowed as a deduction.

''(2) ELECTION.—An election under paragraph (1) shall be made under rules similar to the rules of section 179(c).

''(b) LIMITATIONS.—

''(1) DOLLAR LIMITATION.—With respect to any eligible entity, the aggregate cost which may be taken into account under subsection (a)(1) for any taxable year shall not exceed, when added to any cost taken into account under this section in any preceding taxable year, the dollar amount specified under section 2(e)(2)(A)(ii) of the Health Information Technology Act of 2005.

''(2) APPLICABLE RULES.—For purposes of this subsection, rules similar to the rules of paragraphs (3) and (4) of subsection (b) and paragraphs (6), (7), and (8) of subsection (d) of section 179 shall apply.

''(c) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) QUALIFIED HEALTH CARE INFORMATICS SYSTEM EXPENDITURES.—

''(A) IN GENERAL.—The term 'qualified health care informatics system expenditure'

means, with respect to any taxable year, any direct or indirect costs incurred and properly taken into account with respect to the purchase or installation of equipment and facilities relating to any qualified health care informatics system. Such term shall include so much of the purchase price paid by the lessor of equipment and facilities subject to a lease described in subparagraph (B)(ii) as is attributable to expenditures incurred by the lessee which would otherwise be described in the preceding sentence.

''(B) WHEN EXPENDITURES TAKEN INTO ACCOUNT.—

''(i) IN GENERAL.—Qualified health care informatics system expenditures shall be taken into account under this section only with respect to equipment and facilities—

''(I) the original use of which commences with the taxpayer, and

''(II) which are placed in service after December 31, 2004, and before October 1, 2010.

''(ii) SALE-LEASEBACKS.—For purposes of clause (i), if property—

''(I) is originally placed in service after December 31, 2004, and before October 1, 2010, by any person, and

''(II) sold and leased back by such person within 3 months after the date such property was originally placed in service,

such property shall be treated as originally placed in service not earlier than the date on which such property is used under the leaseback referred to in subclause (II).

''(C) GRANTS, ETC. EXCLUDED.—The term 'qualified health care informatics system expenditure' shall not include any amount to the extent such amount is funded by any grant, contract, or otherwise by another person (or any governmental entity).

''(2) QUALIFIED HEALTH CARE INFORMATICS SYSTEM.—The term 'qualified health care informatics system' means a system which—

''(A) has been individually approved by the Secretary of Health and Human Services for purposes of this section,

"(B) consists of electronic health record systems and other health information technologies, and

"(C) meets the standards adopted by the Secretary of Health and Human Services under section 4 of the Health Information Technology Act of 2005 by not later than the date which is 60 days after the date of the adoption of such standards.

"(3) ELIGIBLE ENTITY.—The term 'eligible entity' has the meaning given such term by section 2(a)(4) of the Health Information Technology Act of 2005.

"(4) PROPERTY USED OUTSIDE THE UNITED STATES, ETC., NOT QUALIFIED.—No expenditures shall be taken into account under subsection (a)(1) with respect to the portion of the cost of any property referred to in section 50(b) or with respect to the portion of the cost of any property specified in an election under section 179.

"(5) ORDINARY INCOME RECAPTURE.—For purposes of section 1245, the amount of the deduction allowable under subsection (a)(1) with respect to any property which is of a character subject to the allowance for depreciation shall be treated as a

deduction allowed for depreciation under section 167.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 263(a)(1) of the Internal Revenue Code of 1986 (relating to capital expenditures) is amended by striking ''or'' at the end of subparagraph (H), by striking the period at the end of subparagraph (I) and inserting '', or'', and by adding at the end the following new subparagraph:

''(J) expenditures for which a deduction is allowed under section 179C.''.

(2) The table of sections for part VI of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 190 the following new item:

''Sec. 179C. Health care informatics system expenditures.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to property placed in service after December 31, 2004.

SEC. 6. SENSE OF THE SENATE.

It is the sense of the Senate that the provisions of, and amendments made by, this Act should achieve deficit neutrality over the 5-year period beginning on October 1, 2005.

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